# Establishing Effective Tobacco Control Partnerships between Tribes and External Agencies

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## Abstract:

Since 2000, the 29 federally recognized tribes of Washington State have contracted for tobacco prevention funds through the state Department of Health. This funding has allowed tribes to develop or enhance internal capacity to conduct culturally appropriate, tribe-specific tobacco prevention and control activities. Fulfilling the state's obligation to recognize tribal sovereignty, this collaborative relationship has been promoted as a model for states working with tribes, and has provided the foundation needed to establish effective tobacco control partnerships between tribes and external agencies.

## The Historical Relationship between Tribal and Non-tribal Tobacco Prevention Programs in Washington State:

Since July 2000, the Washington State Department of Health's Tobacco Prevention and Control Program (TPC) has made funding available to all federally recognized tribes of Washington State (currently 29 tribes) through non-competitive contracts. In accordance with culturally appropriate protocol and the provisions of the 1989 Centennial Accord[1], the DOH discussed all aspects of the proposed contract with the American Indian Health Commission (an organization that represents the health policy interests of Washington's tribes) and with the Northwest Portland Area Indian Health Board (a health service organization directed by the 43 tribes of Washington, Idaho and Oregon) before implementing this contracting process.

Upon receipt of State funds from the Master Settlement Agreement (MSA), Washington Secretary of Health Mary Selecky convened a Tobacco Prevention and Control Council to create a strategic tobacco plan for the state. During the development of this plan, funds were earmarked to support tribal tobacco prevention efforts. During the first two state fiscal years (SFY), $408,000 was available for use by Washington tribes. Based on the experience of Oregon's state tobacco program and upon the request of the American Indian Health Commission, funds were distributed to tribes using a 30:70 formula. Using this funding scheme, 30% of the total amount was divided evenly among all tribes and 70% was distributed based on the tribe's population size (calculated using "Active User Population" numbers generated by the IHS). Under this formula, contract levels ranged from $6,000 for small tribes (later raised to $8,000) to $58,000 for larger tribes. Twenty-three of the then 28 tribes across Washington State chose to contract with DOH. This enabled many to initiate and develop internal capacity for tribe-specific, culturally appropriate tobacco control.

[1] The Accord that acknowledges the government-to-government relationship between Washington State and Tribes, requiring tribal consultation on all matters of mutual concern

In November 2002, the citizens of Washington State voted to increase the state tax on tobacco products. This allowed the Department of Health to increase each tribe's funding level by 25% in SFY 2003, raising the minimum funding level for small tribes to $12,000. Since 2003, 26 tribes have contracted annually with the DOH. A total of $558,000 is currently distributed annually, with contracts ranging from $12,000 to $72,500 per tribe. Today, there is strong support within DOH tobacco program and among all its county and school-based contractors to increase the minimum level of tribal funding in SFY 2006 to around $25,000, totaling nearly $774,000 for the 27 tribes currently under contract.

Funded wholly or in part by the Washington State Department of Health, tribal tobacco programs have successfully established clinic-based cessation programs, youth advocacy and education groups, community-based media campaigns, tobacco-free community events, and have passed a variety of tobacco-related policies. Each program's priorities have been established in relation to self-identified community needs, and activities have been designed with a first-hand knowledge of culturally effective and appropriate practices. As a result, current smoking rates among American Indian and Alaska Native adults in Washington State have slowly decreased in the past five years.

In the past, few partnerships successfully emerged between tribal tobacco programs and external tobacco control agencies in Washington. Prior to state funding, this division was largely due to a lack of capacity within Washington tribes to engage in such partnerships. Without tribal personnel dedicated to tobacco control, external agencies did not know whom to contact within their local tribe(s) to explore ways they might work together. While Tribes expressed knowledge about external programs after state funding was established, tribal leaders and program managers were often hesitant to pursue relationships with outside agencies, citing distrust, conflicting agendas or a history of unsuccessful relationships with non-tribal entities. Community-based and governmental agencies were historically slow to form partnerships with tribes due to their unfamiliarity with the systems, culture, norms, history, and limitations unique to tribal communities. Moreover, unstable partnerships were further perpetuated by fluctuating acknowledgement of and respect for tribal sovereignty by state and county health departments.

## Barriers to Positive Working Relationships:

Upon reflection, tribal tobacco coordinators and external agencies identified a number of conditions that impeded the development of positive working relationships.

Prior to funding, many tribes did not have tobacco control programs with the capacity to form working relationships with external programs. As these programs were created, time and again, tribes felt like they were approached by external agencies seeking to meet their own funding mandates to address health disparities, without truly hearing or acknowledging the tribe's goals, priorities, or needs. Meetings often unfolded with an externally designed plan for what the tribe "could" or "ought" to be

doing. When external agencies came to the table with a pre-determined agenda, interactions with tribal members felt paternalistic and dismissive of the priorities and culturally appropriate activities already in place within the tribe. These interactions lead to unsuccessful attempts to build external relationships, and fostered and reinforced tremendous distrust between the tribes and external groups.

For state and county governments and other external agencies, unfamiliarity with the tribe's priorities, customs, limitations and protocols added to the complexity of building such partnerships. A lack of knowledge about tribal sovereignty, and the relationship between tribal health and tribal economics, often led to tensions about the need for tobacco-related policies governing casinos and smoke shops. Likewise, procedures, staffing, and timelines that were successfully used to engage other communities were not effective when working with tribes, and heightened frustration and disinterest in future partner building.

For both groups, positive interactions were hindered by differing or conflicting expectations about what the partnership should look like, what the relationship would entail, and conflicting expectations from supervising program managers and administrations. The time and energy needed to foster this unique relationship also served as a barrier, as many tribes and agencies were already strapped for staff time and the resources needed to actively engage in face-to-face relationship building.

## Bridging Differences and Sustaining Partnerships:

**Trust and Communication** - Above all, the first step needed to bridge tribal and organizational differences is to establish and sustain open and honest communication. Trust can only be built on the foundation of frequent communication, through meetings, phone calls, emails, presentations, activities, and events. Trust is absolutely necessary for relationships to evolve into working partnerships. Relationships with both the tribe's staff and the tribe as a whole must be built, requiring multiple face-to-face interactions.

Tribal tobacco coordinators often manage or oversee multiple projects or health services. Thus, external agencies must be mindful of their limited time and travel budgets. Whenever possible, face-to-face meetings should be held at the tribe or another location chosen by the tribal coordinator. Once a personal relationship has been established, phone calls and emails will be better received and understood.

**Acknowledge Differences** - Because all matters affecting the welfare of the tribe are within the jurisdiction of the tribe's governing body, permission to engage in partnering activities may require additional time to obtain. Similarly, time may be needed to educate decision makers about new project goals or activities. Partnering activities must also be mindful of that traditional cultural events and activities, including powwows, feasts, celebrations, and mourning periods will affect timelines. Timelines that work effectively for non-tribal partnerships may not be effective in Indian Country. Be flexible and willing to modify customary processes.

Public health agencies are increasingly required to implement only *best practice* activities (practices that have been evaluated and proven effective). Given that there has been little evaluation of tribal practices, conflict can occur between partners when external agencies require that only best practices be used. Partnerships need to be flexible and willing to implement *evidence-based* practices, which rely on quantitative and qualitative information to determine efficacy in tribal communities.

Sensitivity must also be shown for the tribe's traditional relationship with sacred tobacco, and for the role of tobacco sales within the tribe's current economy. For tribes throughout North America, the use of traditional tobacco plants for spiritual, ceremonial, and medicinal purposes goes back thousands of years. Many traditional stories emphasize the sacred properties of the plant, containing both the power to heal if used properly and the power to cause harm if used improperly. Mainstream media messages that portray tobacco as "bad" will be found culturally offensive. Likewise, efforts to alter tribal tobacco sales will be seen as an affront to sovereignty unless approached by supporters from within the tribal community.

**Embrace Similarities** – The ultimate goal of tribal tobacco prevention and control partnerships is to improve the health and well being of American Indian and Alaska Native communities. It is important to focus initial conversations on this mutual goal, and to highlight the strengths and resources that each party can bring to the partnership. Establishing shared, overarching goals and objectives before discussing individual activities will enable the partnership to work most effectively.

External agencies/organizations who want to develop effective partnerships with tribes must value and continually seek tribal opinion and input throughout the "agenda-setting" process. There must be opportunities for ideas and suggestions to be shared, heard, and considered by all participating parties, and for members to educate one another about each organization's unique worldview. Each partner brings valued skills and knowledge to the collaboration, which should be reinforce throughout the process. These steps will ensure tribal boundaries are acknowledged and respected, and will demonstrate to the tribal members that the partnership is truly about the well being of the community.

## Thriving Examples:

The positive working relationship between Washington's tribes and the State Department of Health was borne of state respect for tribal sovereignty and consultation, a willingness to provide non-competitive funding to all interested tribes, a willingness to adapt mainstream materials and approaches for unique tribal circumstances, and a willingness to allow tribes to implement culturally appropriate activities that frequently deviate from the science-based norm. This funding provided tribes with the capacity needed to establish effective tobacco control partnerships with external agencies, and has been promoted as a model for states working with tribes.

In Eastern Washington, the Yakama Nation and the American Cancer Society joined forces to develop and implement a native youth SpeakOut curriculum. Based on a shared desire to build capacity among youth as effective community advocates, the partnership has trained nearly 20 Yakama youth on topics regarding tribal tobacco use. This successful project has empowered teens to "speak out" to local newspaper and television stations, and has opened the door for additional program partnerships.

In the Coastal region, collaborations have developed between the Tulalip Tribes and the Snohomish County Health District. The county health district applied for and received a $75,000 "enhancement grant" from the state tobacco program to help the tribe build capacity for tobacco prevention and control. Though the partnership was initially challenged by many of the barriers discussed above, each party's commitment to a successful partnership led to greater inter-cultural understanding and mutually beneficial outcomes. This partnership eventually became well received by both the Tribe and the County health district, and has been recognized as an effective model by the Washington State Department of Health, the Northwest Portland Area Indian Health Board, and the Center for Disease Control and Prevention.

In Northwestern Washington, the Nooksack Tribe and the Nooksack Valley School District have partnered to provide tobacco education classes to tribal and non-tribal eighth grade students. Through this collaborative effort, six, one and one half hour interactive presentations were developed and are now being taught to students each school year. The partnership successfully educates students about both the health risks associated with tobacco use and the traditional role of tobacco within the tribe, serving the needs and goals of both organizations.

Additionally, the Western Tobacco Prevention Project (WTPP), a support center within the Northwest Portland Area Indian Health Board, collaborates with both the Washington State DOH and Washington's Tribes to provide culturally appropriate technical assistance, training, advocacy, guidance and program support. The WTPP works with tribes to develop and disseminate culturally appropriate tobacco education information, cessation guides and material resources, and actively seeks to support and improve state, county, and tribal partnerships. As a result of the strong partnership that has developed between the State DOH and the WTPP, the Western Tobacco Prevention Project was awarded a contract with the Washington State DOH in 2003 and 2004 to serve as a tobacco liaison to the tribes. Through this contract, the WTPP provides guidance and support to DOH, and ongoing training and assistance to Washington's tribes. Through this partnership, the WTPP has been able to conduct a comprehensive community assessment of all the Washington tribes, has written a workbook to assist tribes in changing tribal tobacco policies, and has developed culturally appropriate social marketing materials for Washington's tribes.

These are just a few of the many successful partnerships that now exist between Washington's tribal tobacco programs, and State and County health departments, local and national tobacco control agencies, and external tribal health organizations.

## The Benefits of Partnerships Between Tribal Nations and Non-Tribal Agencies/Organizations

Strong and effective partnerships can help meet the needs and goals of both entities. For states or counties, tribal partnerships can help agencies address governmental or organizational mandates to eliminate health disparities. For tribes, these partnerships provide access to additional resources, expertise, and manpower to protect or improve the health of the community. Though different, by listening to the needs and protocols that guide decision making for each group, such partnerships can stretch limited budgets, lend additional personnel to needed tasks, bring new perspectives and program ideas to the forefront, provide opportunities for additional program partnerships, and, most importantly, improve community health.

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This Case Study was written by the Western Tobacco Prevention Project, a project of the Northwest Portland Area Indian Health Board. Information contained in this document was obtained during interviews with tribal tobacco program coordinators in Washington State, and through key informant responses to a structured questionnaire. To ensure that the Case Study accurately reflects the views and experiences of those portrayed within, the document was distributed to all parties for their approval prior to distribution.